MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF DRUG CONTROL POLICY

TREATMENT POLICY #06

SUBJECT: Individualized Treatment Planning

ISSUED: September 22, 2006

EFFECTIVE: October 1, 2006

PURPOSE

The purpose of this policy is to establish the requirements for individualized treatment planning. Treatment plans must be a product of the client's active involvement and informed agreement. Direct client involvement in establishing the goals and expectations for treatment is expected to ensure appropriate level of care determination, identify true and realistic needs and increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client.

The treatment planning process can be limited by the information that is gathered in the assessment or by actual treatment planning forms. These treatment forms should be reviewed on at least an annual basis to ensure that the information that is being gathered or the manner in which it is recorded continues to support the individualized treatment planning process.

SCOPE

This policy impacts the coordinating agency (CA) and its provider network of substance abuse treatment and recovery support services.

BACKGROUND

Expectations for Individualized Treatment Planning have been advisory requirements in the contract with the coordinating agencies for the past three years. This policy formalizes these expectations.

REQUIREMENTS

The Administrative Rules for Substance Abuse Programs in Michigan, promulgated under PA 368 of 1978, as amended, state, "A recipient shall participate in the development of his or her treatment plan." [Recipient Rights Rules, Section 305(1)].

All CA providers must also be accredited by one of four national accreditation bodies. Accreditation standards also require evidence of client participation in the treatment planning process.

PROCEDURE

Treatment planning begins at the time the client enters treatment – either directly or based on a referral from an access system – and ends when the client is discharged. Treatment planning is a dynamic process that evolves beyond the first or second session when required documentation has been completed. Throughout the treatment process, as the client's needs change, the treatment plan must be revised to meet the new needs of the client.

The treatment plan is not limited to just the client and the counselor. The client can request any family members, friends or significant others be involved in the treatment process. Once the treatment plan is completed, the client, counselor, and other involved individuals must sign the form indicating understanding of the plan and the expectations.

Establishing Goals and Objectives

The initial step in developing an individualized treatment plan involves the completion of a biopsychosocial assessment. This is a comprehensive assessment that includes current and historical information about the client. From this assessment, the needs and strengths of the client are identified and it is this information that assists the counselor and client in establishing the goals and objectives that will be focused on in treatment. The identified strengths can be used to help meet treatment goals. Examples of strengths might be a healthy support network, stable employment, stable housing, willingness to participate in counseling, etc. After strengths are identified, the counselor assists the client in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the client can provide motivation to participate in treatment and may take the focus off any negative situations that surround the client getting involved in treatment – legal problems, work problems, relationship problems, etc.

Writing the Plan

Once the goals and objectives are jointly decided on, they are recorded in the treatment plan document utilized by the provider. Goals must be stated in the client's words. Each goal that is written down should be directly tied to a need that was identified in the assessment. Once a goal has been identified, then the objectives – the steps that need to be taken to achieve the goal – are recorded. The objective must be developed with the client but do not have to be recorded in the client's exact words. The objectives need to be written in a manner in which they can be measured for progress toward completion along with a targeted completion date. The completion dates must be realistic to the client or the chances of compliance with treatment are greatly reduced.

Establishing Treatment Interventions

The next component of the plan is to determine the intervention(s) that will be used to assist the client in being able to accomplish the objective. In other words – what action will the client take to achieve it and what action will the counselor take to assist the client in achieving the goal. Again, these actions must be mutually agreed upon to provide the best chance of success for the client.

Framework for Treatment

The individualized treatment plan provides the framework by which the treatment should be conducted. Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the treatment plan. When progress notes are written, the note should reflect what goal(s)/objective(s) were addressed during a treatment episode. The progress notes are also where to document any adjustments/changes to the treatment plan. Once a change is decided on, it should then be added to the treatment plan in the format described above.

Treatment Plan Progress Reviews

Treatment plans must be reviewed and this review must be documented in the client record. The frequency of the reviews can be based on the time frame in treatment (60, 90, 120 days) or on the number of treatment episodes that have taken place since admission or since the last review (8, 10, 12 episodes) The reviews must include input from all clinicians/treatment providers involved in the care of the client as well as any other individuals the client has involved in their treatment plan. This review should reflect on the progress the client has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them, and the need to add any additional goals/objectives due to new needs of the client. As with the treatment plan, the client, clinician, and other relevant individuals should sign this review.

The treatment plan and the treatment plan reviews not only serve as tools to provide treatment to the client, they help in the administrative function of service authorization. All decisions concerning, but not limited to, authorizations, length of stay, transfer, discharge, continuing care, and authorizations by CAs must be based on individualized determinations of need and on progress toward treatment goals and objectives. Such decisions must not be based on arbitrary criteria such as pre-determined time or payment limits.

Policy Monitoring and Review

The CA will monitor compliance with individualized treatment planning and these reviews will be made available to ODCP during site visits. ODCP will also review for individualized treatment planning during provider site visits. Reviews of treatment plans will occur in the following manner:

- A review of the biopsychosocial assessment to determine where and how the needs were identified

- A review of the treatment plan to check for:

    1. Matching goals to needs – Needs from assessment to goals on the treatment plan
    2. Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients
    3. Measurable objectives – The ability to determine if and when an objective will be completed

4. Target dates for completion – The dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan
5. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc
6. Signatures – Client, counselor, and involved individuals.

- A review of progress notes to ensure documentation relates to goals and objectives

- A review of the treatment plan progress review to check for:

1. Progress note information matching what is in review
2. Rationale for continuation/discontinuation of goals/objectives
3. New goals and objectives developed with client input
4. Client participation/feedback present in the review
5. Signatures

REFERENCES

Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., & Griffith, J.H. (Eds.) (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.

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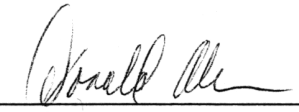
National Institute on Drug Abuse (2000). *Principles of Drug Addiction Treatment*. Washington, D.C.: NIDA.

Scott D. Miller, Barry L. Duncan. (2000). Paradigm Lost: From Model-Driven to Client-Directed, Outcome-Informed Clinical Work. Institute for the Study of Therapeutic Change, Chicago, Illinois

APPROVED BY: 

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